

INFORMED CONSENT FOR TELEMEDICINE

I am agreeing to the use of Telemedicine as a means of participating in clinical services with Georgia Pines Community Service Board. I have had the advantages and limitations explained to me to my satisfaction, including the following information:

- The names, roles and purposes of participating staff in telemedicine sessions.
- What services are being provided and how long the sessions will typically last.
- What steps have been taken to protect my rights to privacy and confidentiality during the provision of these services.
- How sessions will be documented and maintained in medical records.
- Who will be responsible for the potential limitations in the technology employed, including risks of information disclosure.
- My right to refuse or discontinue participation in telemedicine services and know what alternative modes of treatment are available.
- The fact that all confidentiality and privacy laws protecting my Personal Health Information apply to all communication during telemedicine services, including the limitations of such rights when my or another's well-being is threatened.
- Possible misunderstandings that may occur when visual cues are absent or limited in communications.

Participant's/Legal Representatives Signature

Date